

# **King County Public Health Operational Master Plan**

## **Policy Environment Background Paper**

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*Please note: This background paper should be viewed as a dynamic product. It is likely that new information will continue to be provided during the life of this project. The reader should regard this paper together with the companion papers on role definition, policy environment and funding as initial guidance for the production of a broad policy framework.*

## **Executive Summary and Implications for Next Steps**

In this executive summary we provide our interpretation of the significance and meaning of the observations in this paper as they relate to a broad policy framework for public health in King County.

In comparison to the CMHD included in this analysis, PHSKC is more complex in its mandates, the mix of services provided, and its governance structure.

In general, PHSKC exists within a policy environment that mandates services from the Federal government (via state directives), state statutes (RCW) and regulations (WAC), and local ordinances via King County Government, the City of Seattle, the King County suburban cities, and the King County Board of Health.

Mandates provide considerable structure and direction for what programs and services are provided. Yet PHSKC retains a certain amount of flexibility within which they have created structures for setting programming and funding priorities. For example, the department has responded to mandates and requirements by:

- organizing and delivering services along the framework of the ten essential public health services;
- using a quality management framework;
- focusing leadership in specific areas through strategic planning;
- providing measurable targets within a performance management framework.

PHSKC provided us with an analysis of the impact of the policy environment on its ability to improve the health of King County. This analysis, organized by the 10 Essential Services and cross-walked with the Washington State Public Health Standards, is found in Appendix F.

Key observations from this report are summarized below and followed by our interpretation of their significance and meaning for a broad policy framework for public health in King County. First, the key observations:

- **This analysis of the policy environment for public health includes an examination of government mandates; governance structures; functions and services; and policies and tools for operations and accountability.** We examined these factors from the perspective of national norms and through a comparison of how they influence the policy environment for PHSKC and the CMHD selected for comparison.
- **Policy environments differ from community to community.** The policy environment of the comparable metropolitan health departments (CMHD) is influenced by a number of factors including the historical context, local capacity, and community dynamics. Therefore, as would be expected, there are some notable differences between PHSKC and the five CMHD. This is also due, in part, because these CMHD were not chosen for their service mix. Rather they were chosen for their potential value to the overall project by virtue of the make-up of their populations, evidence of best practices, innovation and policy issues they are facing.
- **Washington State has moved from a “service formula approach” to a “functions and essential services approach”.** The categorical “service formula” approach for mandating public health programs in most other states allows very limited flexibility for local and state response to emerging public health problems, particularly when compared to the “functions and essential services” approach used in Washington. Washington’s “functions and essential services” model for defining mandates facilitates responsiveness because the focus is on broad activities such as surveillance which can be marshaled to address any disease outbreak.
- **State allocation of Grant funding is usually based on population.** Allocation methods by DOH often are designed to assure core capabilities across the state rather than allocating resources on a basis of risk, vulnerability and levels of complexity. For example, state funding policies

distribute resources evenly by county population, so King County gets 40% of the funding yet it has 60% of the statewide tuberculosis cases. With half the statewide total of hospital beds located in this one metro county, resources are still allocated on a per capita basis. This distribution of funds has an impact on the ability of PHSKC to coordinate preparedness efforts across the entire health care system.

- **Government mandates impacting all major metropolitan health departments (MMHD), are numerous.** Mandates impacting PHSKC include
  - federal statutes and regulations
  - state statutes and regulations
  - local ordinances from King County governments
  - local rules from the King County Board of Health
  - interlocal agreements with the City of Seattle
  - the state Public Health Improvement Plan which sets forth practice standards.
- **The Ten Essential Public Health Services guide policy about core functions and responsibilities of local public health agencies and their system partners.** Based on this framework, public/private entities and coalitions have promulgated frameworks for quality management, strategic planning, leadership development, and performance management using quantitative targets for measuring accountability. While not mandates, both the essential services and these tools have become accepted national norms for public health practice.
- **While PHSKC is similar to CMHD in many ways, there are notable differences.** PHSKC plays a larger role than the other CMHD in
  - Conducting inspection and licensing activities
  - Providing primary care services directly
  - Operating school-based clinics
  - Providing correctional health services
  - Providing emergency medical services
  - Doing work related to the built environment

PHSKC does not provide behavioral/mental health services, but its comparison CMHD either provide them directly or contract for them.

- **The governance of PHSKC is perhaps more complex than in other CMHD.** PHSKC is considered a city-county health department, one of five types of health departments. The department is governed by King County and the Board of Health, each with different authorities. Further, the City of Seattle and the suburban cities in the county all play roles in governance. The result is a complex model of governance.
- **Financing public health presents significant policy challenges.** Among the factors associated with financing public health, many are related to the challenges in obtaining accurate assessments of what constitutes an adequate infrastructure to address public health responsibilities and core programs. This will be a topic of the background paper on funding.

Important implications for next steps based on this description of the policy environment include:

- **The concept of a local public health system is very important, but system effectiveness has not been measured in King County.** Policies regarding what roles should be performed by PHSKC might be more clearly determined if system capacity and effectiveness were measured. Consideration of the NACCHO Operational Definition will also help identify service gaps within the system and help policy makers assign specific roles to the health department.
- **Some mandates are vague and need clarification.** Some services and activities are provided by PHSKC because they are considered to be mandates. However, room for greater flexibility in service selection may exist with some “mandates” because of unclear legal language, use of outdated language (as in the Joint Executive Committee Agreement), and questionable interpretation of the language. Competing demands for limited resources suggest that mandates be clarified.
- **Services that are “core” to the health department’s mission are undefined.** The Seattle agreement is based on the WAC in place in the late 1990’s. The WAC was widely interpreted as constituting mandates for local health departments and is the basis for the King County responsibility for “core services”

with Seattle. The WAC was replaced by the Washington State Public Health Standards. Perhaps owing to this set of circumstances, the staff, when asked by Milne & Associates, could not identify what services are core to their mission.

- **King County's and PHSKC's participation in state level policy planning, development and review is important.** A significant portion of the mandates that affect PHSKC are generated within the state, by the legislature, State Department of Health and State Board of Health. Information from stakeholder interviews suggested that PHSKC does not always play an active role in those efforts. Since a significant portion of the mandates that affect PHSKC are generated within the state, the health department's level of participation in state level policy planning, development and review is important.
- **Lack of activity by the Joint Executive Committee might be problematic.** The agreement between the City of Seattle and King County was based, at least in part, on state laws then in place. Given subsequent changes in law, there is a need for clarity regarding state mandates and to assure that the City-County agreement remains current with changing law.
- **Reexamination of policy options related to the PHSKC emphasis on providing direct services to individuals should be considered.** The rationale for PHSKC's placing emphasis on providing services directly to individuals is explained in part because of continued limited access to care for individuals and families in King County. There are waiting lists for the State's Basic Health Plan and concern over the widening disparities in health care for minority and immigrant children. For these and other reasons, PHSKC provides primary care through direct access and through coordination with community partners including community clinics. However, PHSKC seems to play a limited role in convening, facilitating, coordinating, and/or contracting to improve access to the broader healthcare system. It was noted that CMHD contract with external organizations for more services than is the case with PHSKC, particularly for primary care. These CMHD discontinued the direct delivery of primary care services, providing instead an indirect role of assuring funding

and/or fulfilling the role of convening, organizing, and catalyzing action.

Some stakeholders perceive a possible conflict of interest in PHSKC's "competing" for primary care services with clinics with which it contracts. That perception alone justifies a reexamination of the options but care should be taken not to dismantle existing capacity without a thorough analysis of the impact of policy change.

- **Application of the PHSKC "Public Health Priorities and Funding Policies" document is unclear.** The public health priorities and funding policies for PHSKC are described in the 2003 King County budget proviso. Developed by PHSKC and approved by the King County Council, this document outlines the mechanism that PHSKC uses to strategically manage toward service priorities and make decisions about service provision given their need to serve the whole of King County. It is not clear if the policy is employed in making choices between competing demands or in considering new program opportunities.



## Introduction

King County contracted with Milne & Associates, LLC, to produce a Public Health Operational Master Plan. One of the early deliverables in the project (Deliverable E) is production of a white paper defining the policy environment in which Public Health Seattle-King County (PHSKC) operates. Specifically, we were asked to describe:

- Mandates and needs for PHSKC as compared to other CMHD (national, state, local, grants, contracts, emergent events and priority issues).
- Types and intensity of functions and services CMHD and PHSKC provide, including level and range of service, in response to these mandates and the impact on the role of the CMHD in the community
- Approaches CMHD and PHSKC use for determining the array and configuration of, and investment level for, functions and services.
- Compare the governance structure of PHSKC with that of other CMHD including structures and processes for management, oversight, and accountability. For purposes of comparison, the following metropolitan health departments were used: Alameda County (CA), Columbus City (OH), Davidson County (TN), Miami-Dade County (FL), and Nassau County (NY). (hereafter abbreviated as comparison metropolitan health departments (CMHD)).

Numerous documents were reviewed in our development of this paper including national and state reports and articles on public health policy and infrastructure, data and staff input from PHSKC, and information from the five CMHD. At this point in time our data on the CMHD is limited to website reviews, leadership interviews and some of their NACCHO profiles. As we continue to gather data, the analysis on the policy environment will become more refined.

To guide our thinking about the different components that make up a health department policy environment, Table 1 (next page) was constructed that outlines the major forces defining the approaches to public health system mandates, functions, services, investment levels, and governance structures. The paper itself describes these forces in additional detail. We have included a glossary of public health terms (Appendix A) and a number of appendices that provide additional information about some of the public health frameworks.

**Table 1: Policy Environment**

	<b><u>Normative</u></b>	<b><u>Comparative with CMHD</u></b>	<b><u>Descriptive (PHSKC)</u></b>
	<ul style="list-style-type: none"> <li>National Public Health Frameworks</li> <li>Federal government requirements</li> <li>Public Health Law</li> </ul>	<p>Description of each of the five comparison metropolitan health department in relation to the normative.</p> <ul style="list-style-type: none"> <li>Nassau</li> <li>Miami-Dade County</li> <li>Columbus</li> <li>Nashville-Davidson</li> <li>Alameda County</li> </ul>	<p>Description of Public Health Seattle King County's "practice" and experience in relation to mandates, strategic management and operations and accountability.</p>
<b><u>Government Mandates</u></b>  What is mandated or expected within governmental public health?	<ul style="list-style-type: none"> <li>10 Essential Services (ES)</li> <li>Healthy People in Healthy Communities</li> <li>Federal grant requirements</li> <li>Model Public Health Statutes</li> </ul>	<ul style="list-style-type: none"> <li>10 ES used by all to varying degrees</li> <li>Legislative mandates important but not sole determinant for most</li> <li>Grants and contracts</li> </ul>	<ul style="list-style-type: none"> <li>10 Essential Services</li> <li>Federal, state and local mandates</li> <li>Grants and contracts</li> </ul>
<b><u>Functions and Services</u></b>  How are policy decisions made on non-mandated services?	<ul style="list-style-type: none"> <li>Strategic planning</li> <li>MAPP</li> <li>APEX/PH</li> <li>PACE-EH</li> <li>Model Standards.</li> <li>Healthy People 2010</li> <li>National Public Health Leadership Program</li> </ul>	<p>All but one do strategic planning</p> <ul style="list-style-type: none"> <li>MAPP used by most</li> <li>Leadership is most important</li> <li>all use community assessment to set direction</li> </ul>	<ul style="list-style-type: none"> <li>PHSKC uses strategic planning processes that include elements similar to those in the MAPP process, such as assessment of community health, assessment of systems capacities, assessment of community assets and values.</li> <li>Full array of public health services are provided including some that are contracted or delegated.</li> </ul>
<b><u>Policies and Tools for Operations and Accountability</u></b>  <ul style="list-style-type: none"> <li>Performance measurement</li> <li>Program evaluation</li> <li>Fiscal accountability</li> </ul>	<ul style="list-style-type: none"> <li>NPHPS</li> <li>TQM/CQI</li> <li>CAST-5</li> </ul>	<ul style="list-style-type: none"> <li>Baldrige process</li> <li>Health Report Card</li> </ul>	<ul style="list-style-type: none"> <li>Quality management framework</li> <li>Performance management framework</li> <li>State Standards/PHIP</li> <li>Budgetary Accountability</li> </ul>

**Acronyms used:**

IOM = Institute of Medicine

MAPP = Managing Action through Planning and Partnerships (NACCHO)

APEX/PH = Assessment Protocol for Excellence in Public Health (NACCHO)

PACE-EH = Protocol for Assessing Community Excellence in Environmental Health (NACCHO)

NPHPS = National Public Health Performance Standards Program (CDC)

CAST-5 = Capacity Assessment for State Title V (Maternal & Child Health) (HRSA)

TQM/CQI = Total Quality Management/Continuous Quality Improvement

## **Section 1: Government Mandates for Public Health**

### **Overview**

Historically the US public health system has developed over time to protect the public from a variety of diseases, hazards, and behaviors, primarily through prevention, protection, and health promotion strategies mandated by the federal, state, and local government. The ways in which these mandates have been defined, as well as ways functions, programs, and policies have been created, vary dramatically across the US. In addition, the term “mandate” has not always been clearly understood and has caused confusion among public health leaders. Questions arise, for example, about what programs are absolutely required by federal, state, and local statutes, and what programs are essential because of specific community-based health problems and needs. Programs that are essential to fulfilling the mission of the health department may not be mandated, but fill an identified need are usually considered core programs.

For the purposes of this paper, we have defined mandates as “those programs, services, and activities which are explicitly required by federal, state, or local laws and regulations.” For example, a local health department must provide certain services such as inspecting restaurants or reporting communicable diseases to be in compliance with a law or regulation. The language in the Washington Administrative Code (WAC) and the Revised Codes of Washington (RCW) can also be confusing and subject for varying interpretation. But in general, If the language of a law or regulation states that a program or service “may” or “should” be provided, the service is not considered to be legally mandated, as opposed to language that states the program “shall” be provided.

Policymakers are charged with the task of developing and adopting a broad array of legislative mandates related to the operation of public health. However, they may have limited knowledge and understanding about the nature of public health’s challenges, resource limitations, health status trends, and other factors that confront the day to day delivery of public health services within local and state public health agencies. As a result, legislative mandates that direct the provision of public health services are often specific to a problem, such as healthcare for the homeless, rather than defining a mandated set of general services or functions are in place to take care of a range of problems.

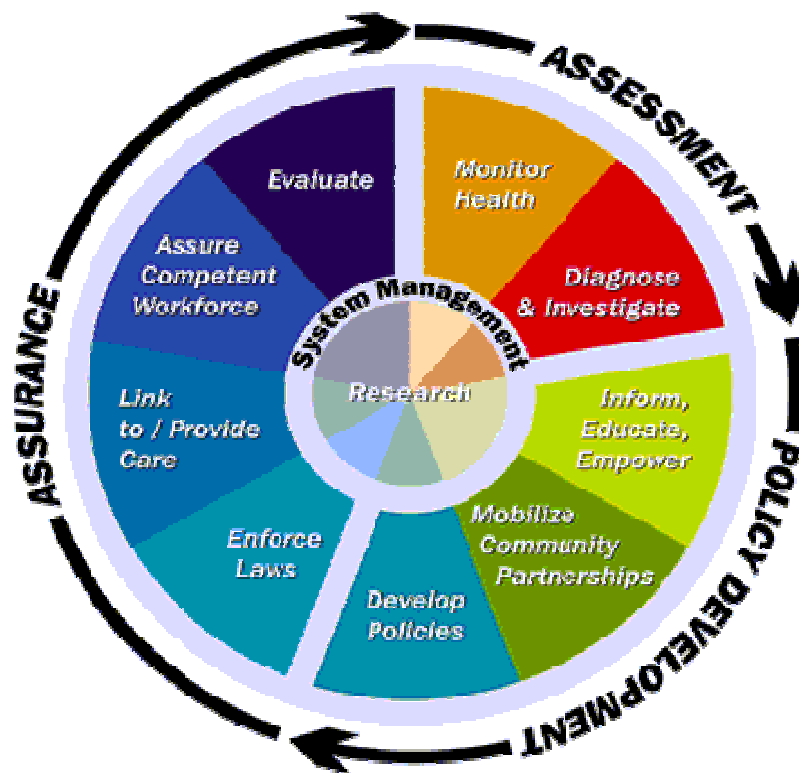
What we often see at the federal level are policy initiatives (as opposed to mandates) designed to guide federal, state, and local public health organizations toward specific goals. For example the series of “Healthy People”<sup>1</sup> reports were created within the US Department of Health and Human Services and are now published every ten years to outline a set of national goals and objectives for health improvement. The reports are accompanied by national data showing current health status data for each of the Healthy People objectives. Most states have created state-level companion documents to Healthy People that reflect state level goals and priorities. For example, the first Washington State Public Health Improvement Plan (1994)<sup>2</sup> contained health status targets for 39 key public health problems. Data compared health status in the state with US data. In 2005 the Key Health Indicators Committee of the Public Health Improvement Partnership process issued a report card on the status of in Washington State<sup>3</sup>. The committee intended that the report card would inform policymakers and the public about important public health issues and would stimulate discussion and improved public health policy by providing solid information. Ultimately, it was intended that more focused actions would result, leading to improved health.

In an effort to define public health, the Institute of Medicine<sup>4</sup> in 1988 recommended the development of a set of public health core functions. These include:

- Assessment: the obligation of every public health agency to monitor the health status and needs of its community regularly and systematically;
- Policy Development: the responsibility of every public health agency to develop comprehensive policies that are based on available knowledge and responsive to communities' health needs; and
- Assurance: the guarantee of governments that agreed-upon, high-priority personal and community health services will be provided to every member of the community by qualified organizations<sup>5</sup>.

While the core functions have been very useful to public health in defining general roles and responsibilities, more specificity was needed, especially at the local level, to match programs and services to the core functions. Beginning in 1995, efforts led by the major public health agencies and organizations in the United States - including the Centers for Disease Control and Prevention (CDC), the American Public Health Association (APHA), the Association of State and Territorial Health Officials (ASTHO), and the National Association of County and City Health Officials (NACCHO) - created the Ten Essential Public Health Services<sup>6</sup> (Figure 1). These functions and services provided a guide to policymakers and public

health officials about how public health could be organized through a systems approach, and what services ought to be in place to assure basic prevention, protection, and health promotion capacities. The public health system at the local level was envisioned as the governmental public health agency and all other public and private organizations whose actions together can create an environment in which people can be healthy.



**Figure 1: Public Health Core Functions and Ten Essential Services**  
Public Health Functions Steering Committee (July 1995)

The ten essential services have helped to define the *practice* of public health<sup>7</sup> (Appendix B & C) Many of these services are invisible to the public. Typically, the public only becomes aware of the need for public health services when a problem develops such as an epidemic of influenza or a foodborne disease outbreak at a local restaurant. What is important for the public to know is not so much what these component parts of the public health system are, but rather that the health department and its partners have in place the capacity to meet the criteria defining a public health system.

Over time, the core functions of public health and the ten essential services have become the “norm” for defining public health and its

associated programs and activities. These functions and services have been incorporated into public health performance measures, health statutory language, and have been used to guide funding decisions. In many places, including the communities served by CMHD, the concept of local public health system has taken hold and collaboration between governmental public health departments and community partners has intensified. However, the extent to which the core functions and essential services have been successful in communicating the role of public health to the public is less well understood.

In response to these communication challenges, in November 2005, the National Association of County and City Health Officials<sup>8</sup> published an operational definition of and standards for a functional local health department (LHD) (Table 2).

The introduction of this document states that “ each community has a unique “public health system” comprising individuals and public and private entities that are engaged in activities that affect the public’s health” Further as NACCHO introduces its recommended standards it states “.... regardless of the particular local public health system, the LHD has a consistent responsibility to intentionally coordinate all public health activities and lead efforts to meet the standards” The standards in Table 2 which have particular emphasis on building systems are highlighted in bold type.

According to NACCHO, “Over the past 15 years, several large-scale efforts have significantly influenced local public health practice by defining public health (Public Health in America, also known as the “10 essential services”), measuring the performance of public health entities (National Public Health Performance Standards Program), setting public health goals (Healthy People (2010), and identifying components of public health systems (The Future of Public Health and The Future of the Public’s Health in the 21st Century, both from the Institute of Medicine). All of these activities have evolved in the absence of a commonly-held notion of what constitutes a functional local public health agency.”

NACCHO developed the operational definition of a local governmental public health agency to “be the basis of future efforts to develop a shared understanding of what people in any community, regardless of size, can expect their governmental public health agency to provide at the local level.” NACCHO suggests that the Operational Definition be used with policymakers and stakeholders to review a local health department’s activities in “light of the Operational Definition”<sup>10</sup>.

**Table 2: NACCHO's Operation Definition of a Functional Local Health Department<sup>9</sup>**

- Understands the specific health issues confronting the community, and how physical, behavioral, environmental, social, and economic conditions affect them.
- Investigates health problems and health threats.
- Prevents, minimizes, and contains adverse health effects from communicable diseases, disease outbreaks from unsafe food and water, chronic diseases, environmental hazards, injuries, and risky health behaviors.
- **Leads planning and response activities for public health emergencies.**
- **Collaborates with other local responders and with state and federal agencies to intervene in other emergencies with public health.**
- Implements health promotion programs.
- **Engages the community to address public health issues.**
- **Develops partnerships with public and private healthcare providers and institutions, community-based organizations, and other government agencies (e.g., housing authority, criminal justice, education) engaged in services that affect health to collectively identify, alleviate, and act on the sources of public health problems.**
- **Coordinates the public health system's efforts in an intentional, non-competitive, and non-duplicative manner.**
- **Addresses health disparities.**
- **Serves as an essential resource for local governing bodies and policymakers on up-to-date public health laws and policies.**
- Provides science-based, timely, and culturally competent health information and health alerts to the media and to the community.
- **Provides its expertise to others who treat or address issues of public health significance.**
- Ensures compliance with public health laws and ordinances, using enforcement authority when appropriate.
- Employs well-trained staff members who have the necessary resources to implement best practices and evidence-based programs and interventions.
- Facilitates research efforts, when approached by researchers that benefit the community.
- Uses and contributes to the evidence base of public health.
- **Strategically plans its services and activities, evaluates performance and outcomes, and makes adjustments as needed to continually improve its effectiveness, enhance the community's health status, and meet the community's expectation.**

***(Emphasis added)***

## **Approaches to Mandates and Policy**

### Federal Mandates and Policies:

At the national level, Congress and administrative bodies set policy, mandate provision of public health services and make available grant programs which address problems of national concern. While these grants provide critically important resources, they also, in most instances, dictate how services will be provided. The administrative entities include the U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, the Health Resources and Services Administration and the Department of Agriculture. Directives from the federal government can impose unfunded mandates for health services that add to the costs of providing services and which may have an unintended consequence of decreasing access to services and/or interest of some providers in serving vulnerable populations.

An example of a problem created by federal rule promulgation relates to the area of public health preparedness. In spite of the infusion of mammoth amounts of federal resource in this arena, there is no uniform preparedness strategy in place to guide the establishment of goals and objectives, allocation of resources, and identification of policy issues that impact all local health departments. Priorities for disaster preparedness activities and allocation of resources are determined exclusively at the federal and state level with little input incorporated from local health departments and other local first responders. Those priorities have largely focused on targeting and enhancing specific, new capabilities exclusively for bioterrorism response. This approach does not address community health care systems' or public health systems' abilities to respond to all emergencies. Instead, a systematic approach to strengthening the preparedness capabilities of a community's health care system would be of value. Moreover, many feel the allocation of federal resources for public health and hospital preparedness is not proportional to the risk, complexity, or vulnerability of local jurisdictions.

Additional examples of conflicts created by mandates include the following:

- Interpretation services must be available to all non English speaking patients/clients seeking Public Health services. While responsive services should include provision of interpretation services, at issue is



how those services are paid for as a mandate in competition with other worthy services.

- Other federal regulations dictate that patients cannot be turned away because of an inability to pay for services. The ability of a public health organization to manage its budget with strict interpretation of this mandate is problematic at best.
- HIPAA (The Health Insurance Portability and Accountability Act of 1996) has introduced new complexities for collecting mandated disease information and is challenging the ability of clinical programs to communicate with patients/clients.
- Federal regulations that require the delivery of health messages that contradict scientifically accurate messaging have increased the need for resources from other revenue streams to deliver both mandated messages and technically accurate information. For example, requirements for abstinence education have blossomed in the absence of good evidence of effectiveness, while restrictions have been placed on providing facts about family planning methods.

Federal grant programs aren't considered mandates, using the definition we've offered for this paper. Health departments can choose which to apply for. Once a grant is received or contract is established, however, service provision must follow the dictates of the federal agency. Too often, federal programs are promulgated in response to a specific disease or health condition. Such policy restricts flexibility to address broader interconnected health problems. When such policy emerges as federal grants, they become what are referred to as "categorical programs," creating in effect silos which restrict how or to whom the service may be provided. A less flattering term to describe this approach is the "disease of the month" approach. To be sure, each issue has its own set of advocates that work hard to retain and expand funding from Congress while striving to retain the "purity" of scope. It has been said that categorical approaches are the most effective models for appropriating funding and the least effective models for administering programs. Many of the programs run by PHSKC and the CMHD are categorical, including WIC, HIV/AIDS, and Bioterrorism Preparedness.

Not only does the categorical approach limit flexibility at the state and local level, but sometimes the programs continue despite ignoring what may objectively be considered to be higher priorities from the local perspective. Such mandates and programs can become outdated because they do not take into consideration 1) improvements in the health issue resulting from the attention, 2) new scientific findings related

to diseases and hazards or 3) new technological discoveries that change process for public health practice such as surveillance.

According to Erickson, Gostin, et al,<sup>13</sup> a public health law is essential in providing the legal authority for a public health agency to take action to protect the public's health. One should expect to see governmental public health mandates that clarify the infrastructure and responsibilities of the public health system and that assure the provision of 1) modern surveillance techniques including reporting and monitoring of public health, 2) epidemiological investigations in response to outbreaks, 3) testing and screening for existing and emerging conditions, 4) vaccination of vulnerable populations, and 5) responsible and respectful use of quarantine and isolation in cases of communicable diseases<sup>14</sup>.

#### State Mandates and Policies:

In the state of Washington, the legislature passes laws (RCW), and regulations authorized by law are written by the state Department of Health and the State Board of Health. The Department has a wide range of authority, including

- environmental health regulation
- health workforce licensure and regulation
- facilities licensure and regulation
- public health emergency preparedness
- health planning

The State Board of Health has more specific authority in certain areas, including:

- safe and reliable drinking water;
- prevention, control, and abatement of health hazards and nuisances related to the disposal of wastes;
- environmental conditions that threaten public health;
- prevention and control of infectious and noninfectious disease
- health data, including vital statistics.

In most states, legislative mandates are defined by a set of required categorical programs such as maternal and infant health and communicable disease control. Such was the case in Washington State until the late 1990s, when many of the mandates contained in WAC Chapter 246 were replaced by public health standards. Earlier, the core public health functions were included in the Health Services Act of 1993 (E2SSB 5304) as the "essential elements in achieving the objectives of health reform in Washington State"<sup>16</sup>. Based on that legislation, the Washington State Department of Health, local health departments, the

State Board of Health, and many stakeholders in the public and private sectors collaborated to create The Public Health Improvement Plan<sup>17</sup> (PHIP) in 1994. The PHIP has served as a strategic plan for public health in the state and has guided the establishment of performance standards.

Moreover, the PHIP defined the minimum standards and core functions for public health protection and recommended strategies and a schedule for improving public health programs throughout the state. The PHIP continues to be published on a biennial basis and its guidance on public health practice and performance can be seen reflected in the structure and programs of PHSKC. A cross-walk of the PHIP standards to the 10 essential services is in Appendix D. The standards address the following key aspects of public health:

- Understanding health issues
- Protecting people from disease
- Assuring a safe and healthy environment for people
- Promoting healthy living
- Helping people get the services they need.

As stated on the standards' website, "the standards focus on the capacity of our public health agencies to perform certain functions, and not on specific health issues." In this sense the PHIP focuses in a progressive fashion on the official governmental public health agencies and its critical infrastructure. It is a well organized expectation based upon a common set of basic standards and best practices which will help bring about improvements in health. While technically the standards are not yet required to be met by local health departments in the state, it is expected they will be when resources are made available.

The categorical "service formula" approach for mandating public health programs in most other states allows very limited flexibility for local and state response to emerging public health problems, particularly when compared to the "functions and essential services" approach used in Washington. For example, when emerging infections such as SARS and West Nile Virus occur, state and local public health agencies must be able to quickly respond in order to protect the public's health. The categorical service funding model creates problems in that funding would need to be reallocated from existing programs to new activities specifically addressing these emergent diseases. On the other hand, Washington's "functions and essential services" model for defining mandates facilitates responsiveness because the focus is on broad activities such as surveillance which can be marshaled to address any disease outbreak.

The issue of legislated public health mandates has drawn national attention in recent years. The Turning Point Initiative<sup>11</sup>, funded by The Robert Wood Johnson Foundation and housed at the University of Washington School of Public Health and Community Medicine, was developed in part because of concern about adequacy of legislative public health statutes. In 2002, Turning Point published a model state public health act<sup>12</sup> to serve as a tool to assess and revamp public health laws. The model law was intended to be used as a tool that states could adopt or adapt to transform and strengthen the legal framework for public health by comparing their own laws to those in the model. From January 1, 2003 to January 1, 2006, language from the model law has been introduced in part through 90 bills or resolutions in 32 states. Of these bills, 36 have passed. Although the Washington State legislature considered the model act and actually held hearings on one bill, it has not passed any bills based on the model law.

In addition to legislated mandates that derive from the Washington State legislature, agencies such as the Department of Health, the Department of Social and Health Services, and the Department of Ecology, and the governor-appointed State Board of Health all have authority to promulgate regulations. Typically, the Washington State Association of Local Public Health Officials (WSALPHO, the professional organization of local public health directors) plays a fairly significant role in reviewing and reacting to proposed agency rule promulgation as well as legislative bills that are pending.

Participation of the largest local health department in the state in WSALPHO's policy review and comment processes is very important. However, information from stakeholder interviews suggested that PHSKC does not always play an active role in those efforts. Since a significant portion of the mandates that affect PHSKC are generated within the state, the health department's level of participation in state level policy planning, development and review is important.

### **PHSKC Mandates**

The policy environment within which Public Health Seattle King County currently functions includes a service area that ranks as the 12<sup>th</sup> largest county in the United States with one third of Washington State's population and a budget of over \$235 million<sup>15</sup>. With a workforce of approximately 1700 employees covering the full range of skills required to provide quality public health services, the PHSKC is well positioned with

capacity to fulfill its system responsibilities in assuring the ten essential services of public health.

In addition to the federal mandates discussed earlier, the legal basis for PHSKC's public health authority is extensive and includes more than 100 references in Washington State RCW and over 20 references in the Washington Administrative Code. However, some of that language is phrased "permissively," calling into question which are actual mandates. The WAC referenced earlier that was replaced by the Washington State Public Health Standards was widely interpreted as constituting mandates for local health departments and is the basis for the King County responsibility for "core services" in its agreement with Seattle (Joint Executive Committee Agreement). However, the operative word in that regulation was "should" and not "shall." In other words, the services referenced (and sometimes taken as mandates) were never truly required to be provided.

PHSKC is one of 35 local public health agencies serving the state of Washington. In addition to the 35 local health agencies, the State's public health system includes a freestanding Department of Health and a State Board of Health with rule making authority. Washington State's local public health agencies are organized by one of three primary structures: county, city-county, and district agencies. PHSKC is a city-county agency with contractual relationships with the city of Seattle and multiple suburban cities. Washington State is a 'Home Rule' State, which means that local jurisdictions, including municipalities, have powers to set policies. The local policy environment is highly complex and includes a number of policy making bodies: the King County Board of Health, the King County Council, City of Seattle, and 37 Suburban City Councils, and 19 school boards.

The King County Board of Health, whose mandated role is to oversee "all matters pertaining to the preservation of the life and health" of the population, has policy influence over PHSKC because it represents the King County Council, Seattle City Council and suburban cities. (RCW 70.05.060) Other county departments that create and influence public health policy include the Department of Natural Resources and Parks, the Department of Transportation, the Department of Adult and Juvenile Detention, the Department of Community and Human Services. In addition, regional entities, such as the Puget Sound Regional Council operate in the local jurisdiction.

An agreement between King County government and the City of Seattle places the policy and statutory authority for the PHSKC with King County.

The City of Seattle's responsibility rests within its own voluntary financial contribution to the Department and "influence" over policies that impact services in the city. The agreement includes language that directs the Board of Health to enact and enforce local public health regulations. At the time that this agreement was developed in 1996, a Joint Executive Committee was established (Mayor, County Executive, Director of the Department) whose role was to implement and monitor Board of Health directives and policy and serve as a forum for conflict resolution. According to information received through stakeholder interviews, the Joint Executive Committee is not currently active. The City of Seattle's interest in influencing PHSKC's approach to services can be seen in the City of Seattle Healthy Communities Initiative, Appendix E. It is also of interest to note here that the service responsibilities outlined in the agreement were based on the previously mentioned WAC which was replaced by the public health standards. The language of the WAC defined services that "counties should provide" through health departments.

Lack of activity by the Joint Executive Committee might be problematic, particularly given the need for clarity regarding state mandates and to assure that the City-County agreement remains current with changing law.

PHSKC is the recipient of a number of grants administered by the State Department of Health (DOH). In several cases, grants received by PHSKC are also received by other health departments in the state. Allocation methods by DOH often are designed to assure core capabilities across the state rather than allocating resources on a basis of risk, vulnerability and levels of complexity. For example, state funding policies distribute resources evenly by county population, so King County gets 40% of the funding yet it has 60% of the statewide tuberculosis cases. With half the statewide total of hospital beds located in this one metro county, resources are still allocated on a per capita basis. This distribution of funds has an impact on the ability of PHSKC to coordinate preparedness efforts across the entire health care system.

In addition, PHSKC is the recipient of many program and research grants, all of which have their own set of required deliverables which may limit flexibility. For example:

- Assessment activities are considered an essential, basic function of local health departments; funding for these activities have traditionally been from local and state resources. An increasing

proportion of assessment activities performed by PHSKC are funded as a component of grants. This necessary shift results from the inability of limited local and state governmental funds to keep pace with inflation.

- Many times, grant opportunities are not available for or do not allow for implementation and evaluation of promising programs. Thus, expansion of the evidence-based body of work in public health progresses slower than other health areas.

Milne & Associates asked department staff how the policy environment affects their ability to fulfill PHSKC's role as a major metropolitan health department. Staff responded using the framework of the 10 essential services, providing an analysis of the policy environment for each area. This analysis is in Appendix F.

### **CMHD Mandates**

Similar to PHSKC, stakeholder and local elected official expectations are important but not the sole determinant of services for the CMHD examined. Legislative mandates vary across the CMHD, but since they determine a large portion of services (in one case 95% of services are mandated) they may comprise the most important determinant of the health department's services. Grant "mandates" are restrictive but the health departments were selective about which grants they pursued, usually based on need. In most cases need was determined by community assessments and/or a strategic planning process. Bioterrorism preparedness grants were seen as mixed blessings; while they are providing additional resources for public health, they come with specific requirements that require greater attention from leadership and management, diverting focus from other programs.

All but one CMHD manage mandates through negotiation with policymakers and through integrating the requirements into other programs, or using CMHD size to provide flexibility that may not be available to smaller health departments. Community expectations are an important driver for policy in most CMHD, and these expectations are generally discovered through formal strategic planning processes.

## **Section 2: Public Health Governance, Functions and Services**

### **Overview**

Because public health agencies at the state level are created under different sets of social and political circumstances to meet the needs of individuals living in communities where health status and circumstances vary, state and local public health departments are quite different across the United States. Over half of state health departments are “freestanding,” consisting of a single agency whose primary mission is public health. Most of these freestanding agencies, including Washington’s, have a relationship with a state board of health and over 40% have a district or regional structure that serves as an intermediary with local public health jurisdictions. Those state health departments not freestanding are located within a “super agency” whose mission is broader than public health; often including human services and Medicaid functions. The vast majority of state public health agencies maintain the authority to propose budget and substantive legislation to policymakers. Less than half of the state health departments have a centralized form of local public health, giving the state agency the oversight of local agencies. One of the comparable CMHD is from such a state (Florida). In most cases (97.9%) the state agency acts as the state’s public health authority.<sup>18</sup>

In Washington State, public health governance uses the decentralized model. The Washington State Department of Health is a freestanding “cabinet-level” agency whose Secretary is appointed by and accountable to the Governor. Washington’s 35 local health departments are independent from the state in terms of governance but are closely associated through contracts, organizational affiliations (Association of Washington Counties) and through numerous joint planning initiatives (Public Health Improvement Partnership).

Local public health jurisdictions have developed in response to local needs and priorities, and vary widely. According to NACCHO’s Chartbook<sup>19</sup> (1999, 2001) on local public health infrastructure, the highest priority services for metropolitan public health agencies are communicable disease control, environment health, child health, and regulatory inspections. Table 3, on the next page, shows the percent of metropolitan health departments that provide different types of public health services. The direct provision of services means that the agency provides it themselves as opposed to contracting the service out to another organization.

In 2001, an updated version of the Chartbook continued to show that no two local health departments are identical in structure or programs provided. For example, of the 3,000 local health departments in the US, 4% serve populations of 500 thousand or more; 50% serve populations of less



than 25 thousand. It was reported that 60% of all local health departments, regardless of size, are county based, while 10% are city based, and 7% are a combined city-county health department. Lastly, 15% are township health departments, and 8% are multi-county. Most local health departments, regardless of type, report to a local board of health (56% of total; 66% of City-County) while only 9% directly governed by a city council or county council.

**Table 3**  
**% of Metropolitan Health Departments Direct Provision of Services**  
**(NACCHO Chartbook)**

Food Safety	89%
Communicable Disease Control	77%
Epidemiology & Surveillance	72%
Sewage Disposal	71%
Tuberculosis Testing	67%
Childhood Immunizations	64%
Private Drinking Water	63%
Community Outreach & Education	62%
Vector Control	61%
Lead Screening & Abatement	58%
High Blood Pressure Screening	55%
Community Assessment	54%
STD Testing & Counseling	48%
HIV/Aids Testing & Counseling	47%
Emergency Response	46%
Tuberculosis Treatment	46%
Indoor air Quality	44%
WIC	43%
Maternal Health	40%
EPSDT	35%
Diabetes Screening	35%
Surface Water Pollution	31%
Cardiovascular Screening	31%
Family Planning	31%
Cancer Screening	28%
Dental Health	22%
Prenatal Care	22%
HIV/AIDS Treatment	15%

Financing local public health agencies may be the greatest challenge faced by policymakers and public health leaders. The factors associated with financing public health are related to accurate assessments of the

capacity required for adequate infrastructure and public health programs. For example, programs created to protect the public's health from hazards now include a major focus on preparedness for bioterrorism and emerging infections such as avian influenza. The enormity of the shortfall for adequate funds to address these types of issues has taken policymakers by surprise.

Large metropolitan health departments face the major responsibility for preparedness activities since they serve the majority of the US population and have the necessary skills within the workforce to provide the types of sophisticated assessment, surveillance, and response technology required<sup>20</sup>. One thing learned from the development of the CDC preparedness plans was that in terms of protecting the public from threats such as terrorism, the public health workforce must coordinate and work with partners in such departments as police and fire as well as private health providers.

The challenge of developing new programs and structures to respond to issues such as bioterrorism is often related to financing and may be hampered by the mechanisms used to fund local health departments-- Federal funds typically go to state health departments and then get "passed through" to local health departments by the state. This approach assumes that the state will be strategic in developing a formula that parses out the funds in a manner that will meet the needs of the state's population. This is not always the case, leaving some major metropolitan health departments to seek funds directly from the Federal government or from alternate funding sources such as foundations.<sup>21</sup>

### **PHSKC Functions and Services**

The mission of the PHSKC as stated on its website is to achieve and sustain healthy people and healthy communities throughout King County by providing public health services which promote health and prevent disease. This mission is carried out through eight goals: 1) Provide needed or mandated health services & prevention programs to address individual and community health concerns. 2) Assess and monitor the health status of our communities. 3) Prevent disease, injury, disability and premature deaths. 4) Promote healthy living conditions and healthy behaviors. 5) Control and reduce the exposure of individuals & communities to environmental or personal hazards. 6) Employ and retain a skilled workforce that reflects the diversity of the community. 7) Provide for timely, consistent and clear two way communication tailored to the

individual communities Public Health serves. 8) Anticipate and respond to the public health consequences of local emergencies.

The mission and goals are realized through five primary focused services lines depicted Table 4, below.

**Table 4**  
**PHSKC Programs and Services**  
(Source: 2006 Department Business Plan, July 2005)

**Population and Environmental Health:**

- Health Education Services
- Chemical and Physical Hazard Special Projects
- Prevention
- Public health preparedness
- Public Health Laboratory
- Food Protection
- Drinking Water Protection
- Waste Water Disposal

**Emergency Medical Services**

- EMS Basic Life Support Training
- Pre-hospital emergency care

**Targeted Community Health Services**

- Public Health Preparedness
- Family Planning
- Refugee Health Access Program
- Interpretation Services
- HIV/AIDS Program
- Family Support Services
- Occupational Health
- Tuberculosis Control
- Woman, Infants and Children

**Clinical and Primary Care Services**

- Health Care for the Homeless
- Primary Care
- Immunizations
- Child Profile
- Oral Health
- Jail Health Services

**Management and Business Practice**

- Accounting Services
- Budget and Financial Planning
- Compliance Office
- King County board of Health
- Professional Practice Support

The organization of services by functions reflects PHSKC's approach to service delivery. Clinical health services account for 30% of PHSKC revenue streams, including significant patient generated revenues. While a number of local health departments around the country have moved away from the provision of direct clinical services, PHSKC continues to provide substantial safety net services to under and uninsured individuals and families. Also, unlike many local health departments and the CMHD, PHSKC receives significant funding from direct grants from the federal government and from foundations; the two comprise over 15% of the budget.<sup>22</sup>

Clinical services have been developed in response to community needs, as well as to priorities expressed by funding sources and policy-makers at various levels of government. For example, because of continued limited access to care for individuals and families as evidenced by waiting lists for the State's Basic Health Plan and concern over the widening disparities in health care for minority and immigrant children, PHSKC provides primary care through direct access and through coordination with community partners including community clinics. However, PHSKC seems to play a rather limited role in convening, facilitating, coordinating, and/or contracting to improve access to the broader healthcare system. Further, some stakeholders suggested that PHSKC has a conflict of interest in both providing and contracting for primary care services.

The decision of whether to provide clinical personal health services is an important policy issue for local health departments around the country. Many local health departments provide some clinical services, but fewer provide full primary care such as that provided in several of PHSKC clinics. During the early 1990s when there was legislative action around health reform in Washington State and the promise of universal access to health care was a reality (albeit short-lived), local public health departments began to examine their role in providing clinical services to individuals who were either under-insured or un-insured. At that time, a report was developed by the Health Policy Analysis Program at the University of Washington School of Public Health and Community Medicine (Clinical Personal Health Services Technical Assistance Project) <sup>23</sup> that examined the decision making about continuing clinical services within the changing health care environment anticipated from the Health Services Act. While the report is dated, these recommendations from that study still seem relevant today and have been acted on by several health departments in the state:

1. The local health department should actively involve the community in decision-making about whether to transition clinical services to other providers.
2. The local health department should examine the capacity of local providers, health plans, etc. to meet the needs of under-insured and un-insured individuals.
3. The health department should explore the potential for partnerships through which clinical services could be delivered.
4. The health department should set a priority on “population-based” services such as those provided by public health nurses (those that serve the entire population or subpopulation in order to assure health promotion, health protection, and disease prevention).
5. The health department should evaluate its effectiveness and efficiency in providing clinical services in comparison with alternative providers.
6. The health department should critically examine their preferred role and weigh that preference against current capacity, infrastructure, workforce, organizational structure, and community and stakeholder support.

Using these recommendations to examine the provision of clinical services would be a useful component of the master plan and of the next iteration of the PHSKC strategic planning process.

It must also be pointed out that within King County, PHSKC is working in coordination with community partners and local government to promote increased access to health insurance coverage or funding for services directed at un- or under-insured populations. In addition, through the Health Care Coalition on Emergency Preparedness, PHSKC works with community providers and health systems to better coordinate the health care system to respond in the event of an emergency to the care needs of the entire population, with a special emphasis on vulnerable populations.

An examination of the department's policy analysis (Appendix F) demonstrates that PHSKC places its statutory obligations from local government within the context of such national policy statements as the Ten Essential Services. Thus the array of services provided take advantage of investment opportunities by assuring consistency with local mandates and public health practice and priorities at the national level.

## **Functions and Services – Comparison**

All of the CMHD have a similarly large set of services and activities, although it appears that the CMHD contract with external organizations for more of the services than is the case with PHSKC. The most prominent example is primary care. Among the five CMHD, comprehensive primary care is performed directly only by PHSKC. The other CMHD contract for these services. (Note: While Alameda County Health Department, one of the CMHD, does not provide primary care services, another department of county government does. Also, PHSKC staff pointed out that 11 of the 25 largest health departments in the country, including PHSKC, provide comprehensive primary care).

While most of the CMHD have a history of primary care service delivery as part of their past service array, all have moved away from the direct delivery of primary care service to an indirect assurance or funding role, largely due to financial considerations, and the belief by the parent governmental body that other arrangements outside of the health department would be more cost effective. Some also expressed the belief that they were more effective in assuring access by serving in convening, organizing, and catalyst roles than in providing services. The original decision to offer primary care services by CMHD was based more on stakeholder expectations that became formalized within the health department operations and authorized through the local government appropriations, than through a specific legislative mandate. Likewise, the governmental appropriations process seemed to be the mechanism through which these CMHD stopped directly providing primary care clinic services.

Additional examples of areas where PHSKC has a larger direct role in providing these programs than the CMHD include inspection and licensing of solid waste haulers, development and enforcement of smoke-free ordinances, regulation of private drinking water wells, and regulation and inspection of health-related facilities. PHSKC was the only health department within our comparison group that provides school-based clinics, emergency medical services, or environmental work with the built environment. On the other hand, there are several areas where the opposite is true. For example, PHSKC does not provide behavioral/mental health services.

### **Section 3: Policies and Tools for Planning, Operations, and Accountability**

#### **Overview**

The call for greater accountability and performance by agencies at the federal, state and local levels is a theme that has pervaded the public sector over the past two decades. Nationally this has been championed in such books as Osborn and Gabler's Reinventing Government. Vice President Al Gore emphasized government performance initiatives and this initiative was formalized at the federal level by the 1993 Government Performance and Results Act (GPRA), which requires federal agencies to be more accountable for the public funds they administer. As a result, national public health leadership organizations including the two major federal public health agencies (Centers for Disease Control and Prevention, and Health Resources Services Agency), the Institute of Medicine, along with the national professional associations NACCHO, ASTHO and APHA - have embraced this movement and have taken the lead in developing performance management conceptual frameworks and tools for use by state and local public health agencies.

This "movement" to greater accountability has encouraged the development of frameworks and tools for performance enhancing approaches such as strategic planning, performance measurement, standard setting, strategic partnership building, community engagement, program planning and quality management including:

1. The Robert Wood Johnson/Kellogg Foundation's Turning Point Initiative for developing community public health systems.
2. NACCHO's community public health strategic planning tool, Mobilizing Action through Planning and Partnerships (MAPP)
3. NACCHO's agency and community planning tool, Assessment Protocol for Excellence in Public Health (APEX-PH)
4. The federal government's Healthy People 2010 national objectives, and implementation tool, Model Standards
5. CDC's National Public Health Performance Standards (NPHPS)
6. CDC's Planned Approach to Community Health (PATCH)
7. NACCHO's Operational Definition and Standards for Public Health

While the adoption of these frameworks and tools has progressed slowly, the literature reports many cases of successful implementation of several of these initiatives. All of the CMHD in this study have, for example, used MAPP to at least inform strategic direction setting. Such inclusion is good in that it assures more extensive involvement of stakeholders.

## **PHSKC**

At PHSKC, strategic planning for improving community health is a complex process that goes on at many levels in King County: within the department, within the multiple coalitions in which PHSKC participates, with city and regional planning groups. There is no single planning model that is suitable to these diverse planning processes. Many of the processes include elements similar to those included in the MAPP process, such as assessment of community health, assessment of systems capacities, and assessment of community assets.

The public health priorities and funding policies for PHSKC are described in the 2003 King County budget proviso. Developed by PHSKC and approved by the King County Council, this document outlines the mechanism that PHSKC uses to strategically manage toward service priorities and make decisions about service provision given their need to serve the whole of King County. The “Public Health Priorities and Funding Policies”<sup>24</sup> outlines a six step process that aligns resources to priority public health needs. The six steps include:

1. Identify legal mandates and public health standard requirements.
2. Describe the target population served using public health data resources.
3. Define program intervention and required resources for desired outcomes.
4. Assess the greatest needs within the program population.
5. Align resources to programmatic interventions to attain best outcomes with the least harm.
6. Continuous monitoring of health and financial performance outcomes and impacts.

It is unclear whether this “Public Health Priorities and Funding Policies” document is employed in making choices between competing demands and in considering new program opportunities.

In 1999, PHSKC developed a strategic plan that clearly stated the organization emphasizes the core functions of public health (assessment, assurance and policy development) with a focus on population health



and community-wide health promotion and health education. In 2004 the strategic planning effort was renewed by PHSKC's leadership group. The leadership group selected three priority areas (Obesity and Overweight, Public Health Preparedness, and Land Use Planning and Health). They also selected three areas for infrastructure improvement (Grants Support Mechanisms, Human Resources, and Public Health Standards).

The assurance of accountability and quality are evident in several documents created by PHSKC -- the Conceptual Framework for Quality Management, the Quality Improvement Committee responsibilities, and the matrix defining the performance measures for PHSKC programs.

In addition, Washington State law mandates that the state Department of Health "Enter into with each local health jurisdiction performance-based contracts that establish clear measures of the degree to which the local health jurisdiction is attaining the capacity necessary to improve health" (RCW 70.190.130). PHSKC has been audited twice under statute (RCW 43.70.580) Audit findings in both instances showed the department to be in compliance with the majority of measures, and many exemplary practices were noted and are shared on the Department of Health website as examples of best practices<sup>25</sup>.

### **Comparison with CMHD**

All five CMHD sites use or have used the 10 Essential Service framework at one time to organize their strategic plans, focus their services, and communicate about the purpose and role of public health internally and to outside stakeholders. Two sites have moved away from a strict essential services framework, adapting it to their own needs. One now uses the CDC "Healthy People in Healthy Communities" framework.

Four of five do formal strategic planning, following a process that has been internally tailored to the health department or one prescribed by the parent governmental unit. All have used MAPP at least as a reference tool for strategic or community planning. Executive leadership is a very important element in four of the five CMHD in determining services and investments. Leadership seems to be most influential when legal or political mandates are less but also important for negotiating the requirements set forth in mandates with local and state policymakers either directly through information sharing and education or through public health organizations and advocates. Strategic planning is not used extensively by the CMHD that reported that legislative mandates determine services.

All CMHD apply methods of community assessment to understand community needs and determine health department programs. Several use sophisticated methods of community participation, putting a great deal of importance on the role of community input. A variety of needs assessment tools are used, including some national tools and some locally developed.

All of the CMHD have formal methods of performance management and reporting to track and report activities and outcomes. All are very aware of the importance of employing methods to measure and assure accountability for performance management. Two use the parent governmental unit's performance management process. At least one has adopted a private sector model for performance management (Baldrige Quality Award, a national award program to recognize high performance). All do some evaluation in different degrees of sophistication. Most see the value of evaluation and plan to increase efforts in this area.

### **Conclusions and implications for next steps**

In comparison to the CMHD included in this analysis, PHSKC is more complex in its mandates, the mix of services provided, and its governance structure.

In general, PHSKC exists within a policy environment that mandates services from the Federal government (via state directives), state statutes (RCW) and regulations (WAC), and local ordinances via King County Government, the City of Seattle, the King County suburban cities, and the King County Board of Health.

Mandates provide considerable structure and direction for what programs and services are provided. Yet PHSKC retains a certain amount of flexibility within which they have created structures for setting programming and funding priorities. For example, the department has responded to mandates and requirements by:

- organizing and delivering services along the framework of the ten essential public health services;
- using a quality management framework;
- focusing leadership in specific areas through strategic planning;
- providing measurable targets within a performance management framework.

PHSKC provided us with an analysis of the impact of the policy environment on its ability to improve the health of King County. This analysis, organized by the 10 Essential Services and cross-walked with the Washington State Public Health Standards, is found in Appendix F.

Key observations from this report are summarized below and followed by our interpretation of their significance and meaning for a broad policy framework for public health in King County. First, the key observations:

- **This analysis of the policy environment for public health includes an examination of government mandates; governance structures; functions and services; and policies and tools for operations and accountability.** We examined these factors from the perspective of national norms and through a comparison of how they influence the policy environment for PHSKC and the CMHD selected for comparison.
- **Policy environments differ from community to community.** The policy environment of the comparable metropolitan health departments (CMHD) is influenced by a number of factors including the historical context, local capacity, and community dynamics. Therefore, as would be expected, there are some notable differences between PHSKC and the five CMHD. This is also due, in part, because these CMHD were not chosen for their service mix. Rather they were chosen for their potential value to the overall project by virtue of the make-up of their populations, evidence of best practices, innovation and policy issues they are facing.
- **Washington State has moved from a “service formula approach” to a “functions and essential services approach”.** The categorical “service formula” approach for mandating public health programs in most other states allows very limited flexibility for local and state response to emerging public health problems, particularly when compared to the “functions and essential services” approach used in Washington. Washington’s “functions and essential services” model for defining mandates facilitates responsiveness because the focus is on broad activities such as surveillance which can be marshaled to address any disease outbreak.

- **State allocation of Grant funding is usually based on population.** Allocation methods by DOH often are designed to assure core capabilities across the state rather than allocating resources on a basis of risk, vulnerability and levels of complexity. For example, state funding policies distribute resources evenly by county population, so King County gets 40% of the funding yet it has 60% of the statewide tuberculosis cases. With half the statewide total of hospital beds located in this one metro county, resources are still allocated on a per capita basis. This distribution of funds has an impact on the ability of PHSKC to coordinate preparedness efforts across the entire health care system.
- **Government mandates impacting all major metropolitan health departments (MMHD), are numerous.** Mandates impacting PHSKC include
  - federal statutes and regulations
  - state statutes and regulations
  - local ordinances from King County governments
  - local rules from the King County Board of Health
  - interlocal agreements with the City of Seattle
  - the state Public Health Improvement Plan which sets forth practice standards.
- **The Ten Essential Public Health Services guide policy about core functions and responsibilities of local public health agencies and their system partners.** Based on this framework, public/private entities and coalitions have promulgated frameworks for quality management, strategic planning, leadership development, and performance management using quantitative targets for measuring accountability. While not mandates, both the essential services and these tools have become accepted national norms for public health practice.
- **While PHSKC is similar to CMHD in many ways, there are notable differences.** PHSKC plays a larger role than the other CMHD in
  - Conducting inspection and licensing activities
  - Providing primary care services directly
  - Operating school-based clinics
  - Providing correctional health services
  - Providing emergency medical services
  - Doing work related to the built environment

PHSKC does not provide behavioral/mental health services, but its comparison CMHD either provide them directly or contract for them.

- **The governance of PHSKC is perhaps more complex than in other CMHD.** PHSKC is considered a city-county health department, one of five types of health departments. The department is governed by King County and the Board of Health, each with different authorities. Further, the City of Seattle and the suburban cities in the county all play roles in governance. The result is a complex model of governance.
- **Financing public health presents significant policy challenges.** Among the factors associated with financing public health, many are related to the challenges in obtaining accurate assessments of what constitutes an adequate infrastructure to address public health responsibilities and core programs. This will be a topic of the background paper on funding.

Important implications for next steps based on this description of the policy environment include:

- **The concept of a local public health system is very important, but system effectiveness has not been measured in King County.** Policies regarding what roles should be performed by PHSKC might be more clearly determined if system capacity and effectiveness were measured. Consideration of the NACCHO Operational Definition will also help identify service gaps within the system and help policy makers assign specific roles to the health department.
- **Some mandates are vague and need clarification.** Some services and activities are provided by PHSKC because they are considered to be mandates. However, room for greater flexibility in service selection may exist with some “mandates” because of unclear legal language, use of outdated language (as in the Joint Executive Committee Agreement), and questionable interpretation of the language. Competing demands for limited resources suggest that mandates be clarified.

- **Services that are “core” to the health department’s mission are undefined.** The Seattle agreement is based on the WAC in place in the late 1990’s. The WAC was widely interpreted as constituting mandates for local health departments and is the basis for the King County responsibility for “core services” with Seattle. The WAC was replaced by the Washington State Public Health Standards. Perhaps owing to this set of circumstances, the staff, when asked by Milne & Associates, could not identify what services are core to their mission.
- **King County’s and PHSKC’s participation in state level policy planning, development and review is important.** A significant portion of the mandates that affect PHSKC are generated within the state, by the legislature, State Department of Health and State Board of Health. Information from stakeholder interviews suggested that PHSKC does not always play an active role in those efforts. Since a significant portion of the mandates that affect PHSKC are generated within the state, the health department’s level of participation in state level policy planning, development and review is important.
- **Lack of activity by the Joint Executive Committee might be problematic.** The agreement between the City of Seattle and King County was based, at least in part, on state laws then in place. Given subsequent changes in law, there is a need for clarity regarding state mandates and to assure that the City-County agreement remains current with changing law.
- **Reexamination of policy options related to the PHSKC emphasis on providing direct services to individuals should be considered.** The rationale for PHSKC’s placing emphasis on providing services directly to individuals is explained in part because of continued limited access to care for individuals and families in King County. There are waiting lists for the State’s Basic Health Plan and concern over the widening disparities in health care for minority and immigrant children. For these and other reasons, PHSKC provides primary care through direct access and through coordination with community partners including community clinics. However, PHSKC seems to play a limited role in convening, facilitating, coordinating, and/or contracting to improve access to the broader healthcare system. It was noted that CMHD contract with

external organizations for more services than is the case with PHSKC, particularly for primary care. These CMHD discontinued the direct delivery of primary care services, providing instead an indirect role of assuring funding and/or fulfilling the role of convening, organizing, and catalyzing action.

Some stakeholders perceive a possible conflict of interest in PHSKC's "competing" for primary care services with clinics with which it contracts. That perception alone justifies a reexamination of the options but care should be taken not to dismantle existing capacity without a thorough analysis of the impact of policy change.

- **Application of the PHSKC "Public Health Priorities and Funding Policies" document is unclear.** The public health priorities and funding policies for PHSKC are described in the 2003 King County budget proviso. Developed by PHSKC and approved by the King County Council, this document outlines the mechanism that PHSKC uses to strategically manage toward service priorities and make decisions about service provision given their need to serve the whole of King County. It is not clear if the policy is employed in making choices between competing demands or in considering new program opportunities.

## References

1. Healthy People 2010
2. Washington State Department of Health (1994) Public Health Improvement Plan, Olympia, WA.
3. Public Health Improvement Partnership Report Card. See <http://www.doh.wa.gov/PHIP/ReportCard/default.htm>. (Accessed on 4/11/06)
4. Institute of Medicine (1988). The Future of Public Health. National Academy Press, Washington, DC.
5. ([http://www.cdc.gov/cvh/Action\\_Plan/full\\_sec2\\_core\\_functions.htm](http://www.cdc.gov/cvh/Action_Plan/full_sec2_core_functions.htm)).
6. Public Health Functions Steering Committee (1995). See <http://www.health.gov/phfunctions/public.htm>
7. See (<http://www.apha.org/ppp/science/10ES.htm>)
8. See (NACCHO, <http://www.naccho.org/>)
9. Janes, R. (2006) Operational definition will bring the message home to counties. NACCHO Exchange. 5(1).
10. See <http://www.naccho.org/topics/infrastructure/operationaldefinition.cfm>
11. See <http://www.turningpointprogram.org/>
12. Public Health Statue Modernization National Excellence Collaborative (2003). Model State Public Health Act: a tool for Assessing Public Health Laws. Turning Point National Program Office, Seattle, WA. See <http://www.turningpointprogram.org/>
13. Erickson, D., Gostin, L, Street, J. & Mills S.P. (2002) *The Power to Act: Two Model State Statutes*. The Journal of Law, Medicine & Ethics, 30(3): 57-62.
14. Ibid, 13.
15. Plough, A. (2004) *Understanding the Financing and Functions of Metropolitan Health Departments: A Key to Improved Public Health Response*. Journal of Public Health Management and Practice, 10(5): 421-427.
16. Washington State Legislature (1993) The Washington Health Services Act of 1993.
17. Ibid, 2.
18. Beitsch, L., Brooks, R., Grigg, M., & Menachemi, N. (2006) *Structure and Functions of State Public Health Agencies*. American Journal of Public Health, 96(1):167-172.



19. National Association of City and County Health Officials (1999, 2001) Local Public Health Agencies Infrastructure: A Chartbook. Washington DC.
20. Ibid, 15.
21. Ibid, 19.
22. Proviso Report, Public Health Seattle & King County. Public Health Priorities and Funding Policies. 2003 King County Budget.
23. Health Policy Analysis Program (1996) Clinical Personal Health Services Technical Assistance Project. University of Washington.
24. Ibid, 22.
25. See ([www.doh.wa.gov/standards/](http://www.doh.wa.gov/standards/))
26. The City of Seattle Healthy Communities Initiative (Nov. 2005). City of Seattle, Human Services Department. See [www.seattle.gov/humanservices](http://www.seattle.gov/humanservices).

## Appendix A

### Glossary

- **Categorical funding:** governmental funding, usually from the federal level, which is designed to be used in support of specific public health programs and activities. It typically is accompanied with tight limitations on how the funds can be used, even within programs.
- **Clinical services** are provided to individual clients/patients by any of a variety of health professionals, including physicians, nurses, dentists and others, to address specific health issues, including treatment of illness or injury or prevention of health problems.
- **Comparable metropolitan health department (CMHD)** is a term used specifically for this project and describes one of the five CMHD to which PHSKC was compared. They include the health departments serving Alameda County (CA), City of Columbus (OH), Miami-Dade County (FL), Nashville-Davidson County (TN), and Nassau County (NY).
- **EPSDT:** A federally funded program for the “Early and Periodic Screening, Diagnosis and Treatment of children.
- **Essential Public Health Services:** established under the aegis of the federal Department of Health and Human Services in 1994, this list of ten sets of services comprises service categories that must be in place in all communities to assure an adequate local public health system.
- **Evidence-based practices:** public health activities which are designed based upon authenticated studies of efficacy and/or upon established practices.
- **Health Status:** The current state of health for a given group or population, using a variety of indices including illness, injury and death rates, and subjective assessments by members of the population.
- **Local public health agency (LPHA)** is a single governmental organization, regardless of size, providing public health services to the residents of a political jurisdiction; also known as a “local health department.”
- **Local Public Health System:** in any community, the local governmental public health agency and all organizations, agencies and individuals who, through their collective work, improve or have the potential to improve the conditions in which the community population can be healthy.
- **Major metropolitan health department (MMHD)** is a local public health agency which is one of the 25 largest metropolitan health departments in the U.S.; while the size of the population served by MMHDs is widely variable, most provide services of close to a million or more people.

- **Metropolitan health department (MHD)** is a local public health agency that provides services to a political jurisdiction with a population of 350,000 or more.
- **Personal health care:** encompasses the services provided to individual patients by health care providers for the direct benefit of the individual patient. Examples include physical examinations, treatment of infections, family planning services, etc.
- **Population-based public health services** are interventions aimed at promoting health and preventing disease or injury affecting an entire population, including the targeting of risk factors such as environmental factors, tobacco use, poor diet and sedentary lifestyles, and drug/alcohol use.
- **Primary care** constitutes clinical preventive services, first-contact treatment services, and ongoing care for medical conditions commonly encountered by individuals. Primary care is considered “comprehensive” when the primary care health provider assumes responsibility for the overall provision and coordination of medical, behavioral and/or social services addressing a patient's health problems.

## **Appendix B**

### **Ten Essential Services**

1. *Monitor health status to identify and solve community health problems:* This service includes accurate diagnosis of the community's health status; identification of threats to health and assessment of health service needs; timely collection, analysis, and publication of information on access, utilization, costs, and outcomes of personal health services; attention to the vital statistics and health status of specific-groups that are at higher risk than the total population; and collaboration to manage integrated information systems with private providers and health benefit plans.
2. *Diagnose and investigate health problems and health hazards in the community:* This service includes epidemiologic identification of emerging health threats; public health laboratory capability using modern technology to conduct rapid screening and high volume testing; active infectious disease epidemiology programs; and technical capacity for epidemiologic investigation of disease outbreaks and patterns of chronic disease and injury.
3. *Inform, educate, and empower people about health issues:* This service involves social marketing and targeted media public communication; providing accessible health information resources at community levels; active collaboration with personal health care providers to reinforce health promotion messages and programs; and joint health education programs with schools, churches, and worksites.
4. *Mobilize community partnerships and action to identify and solve health problems:* This service involves convening and facilitating community groups and associations, including those not typically considered to be health-related, in undertaking defined preventive, screening, rehabilitation, and support programs; and skilled coalition-building ability in order to draw upon the full range of potential human and material resources in the cause of community health.
5. *Develop policies and plans that support individual and community health efforts:* This service requires leadership development at all levels of public health; systematic community-level and state-level planning for health improvement in all jurisdictions; development and tracking of measurable health objectives as a part of continuous quality improvement strategies; joint evaluation with the medical health care system to define consistent policy regarding prevention and treatment services; and development of codes, regulations and legislation to guide the practice of public health.
6. *Enforce laws and regulations that protect health and ensure safety:* This service involves full enforcement of sanitary codes, especially in the food industry; full protection of drinking water supplies; enforcement of clean air standards; timely follow-up of hazards, preventable injuries, and exposure-related diseases identified in occupational and community settings; monitoring quality of medical services (e.g. laboratory, nursing homes, and home health care); and timely review of new drug, biologic, and medical device applications.

7. *Link people to needed personal health services and assure the provision of health care when otherwise unavailable:* This service (often referred to as "outreach" or "enabling" services) includes assuring effective entry for socially disadvantaged people into a coordinated system of clinical care; culturally and linguistically appropriate materials and staff to assure linkage to services for special population groups; ongoing "care management"; transportation services; targeted health information to high risk population groups; and technical assistance for effective worksite health promotion/disease prevention programs.
8. *Assure a competent public and personal health care workforce:* This service includes education and training for personnel to meet the needs for public and personal health service; efficient processes for licensure of professionals and certification of facilities with regular verification and inspection follow-up; adoption of continuous quality improvement and life-long learning within all licensure and certification programs; active partnerships with professional training programs to assure community-relevant learning experiences for all students; and continuing education in management and leadership development programs for those charged with administrative/executive roles.
9. *Evaluate effectiveness, accessibility, and quality of personal and population-based health services:* This service calls for ongoing evaluation of health programs, based on analysis of health status and service utilization data, to assess program effectiveness and to provide information necessary for allocating resources and reshaping programs.
10. *Research for new insights and innovative solutions to health problems:* This service includes continuous linkage with appropriate institutions of higher learning and research and an internal capacity to mount timely epidemiologic and economic analyses and conduct needed health services research.<sup>7</sup>

**Appendix C:**  
**Essential Public Health Services**  
**The “Lay Version”**  
**Milne & Associates, LLC**  
**2004**

Essential Service Number	Non-Public Health Version
1	What’s going on in my community? How healthy are we?
2	Are we ready to respond to health problems or threats in my county? How quickly do we find out about problems? How effective is our response?
3	How well do we keep all segments of our community informed about health issues?
4	How well do we really get people engaged in local health issues?
5	What local policies in both government and the private sector promote health in my community? How effective are we in setting healthy local policies?
6	When we enforce health regulations, are we technically competent, fair, and effective?
7	Are people in my community receiving the medical care they need?
8	Do we have a competent public health staff? How can we be sure that our staff stays current?
9	Are we doing any good? Are we doing things right? Are we doing the right things?
10	Are we discovering and using new ways to get the job done?

## **Appendix D**

### **Crosswalk of Core Functions and 10 Essential Services to Washington State Public Health Standards**

The following information compares the federal framework of 10 Essential Services of Public Health with the Standards for Public Health in Washington State. Local and state health officials drafted the standards with frequent reference to the 10 Essential Services, but they did not use the federal framework to organize their work. Instead, they chose to develop standards in five topic areas. For each area, they sought to assure that the 10 Essential Services were addressed. Please note that the standards, as referenced here, are abbreviated. An entire standard and its measures must be read to understand its scope.

The 10 Essential Services are:

#### **Assessment**

- Monitor health status of the community.
- Diagnose and investigate health problems and hazards.
- Inform and educate people about health issues.

#### **Policy Development**

- Mobilize partnerships to solve community problems.
- Support policies and plans to achieve health goals.

#### **Assurance**

- Enforce laws and regulations to achieve health goals.
- Link people to needed personal health services.
- Ensure a skilled public health workforce.
- Evaluate effectiveness, accessibility, and quality of health services.
- Research and apply innovative solutions.

**Each Standard is linked to the relevant 10 Essential Services placed in parentheses**

#### **Assessment**

1. Assessment skills and tools in place (Monitor, Investigate, Workforce)
2. Information collected, analyzed, and disseminated (Monitor, Investigate, Workforce)
3. Effectiveness of programs is evaluated (Monitor, Workforce, Evaluate)
4. Health policy reflects assessment information (Inform, Mobilize, Policies)
5. Confidentiality and security of data protected (Workforce)

#### **Communicable disease**

1. Surveillance and reporting system maintained (Monitor, Investigate, Inform, Enforce, Workforce, Research)
2. Response plans delineate roles (Inform, Mobilize, Workforce)
3. Documented investigation and control procedures (Investigate, Policies, Enforce, Services, Workforce, Evaluate)
4. Urgent messages communicated quickly (Inform, Mobilize, Services, Workforce)
5. Response plans routinely evaluated (Inform, Workforce, Evaluate, Research)

#### **Environmental health**

1. Environmental health education planned (Investigate, Inform, Mobilize, Workforce)
2. Response prepared for environmental threats (Monitor, Investigate, Mobilize, Services, Workforce, Research)
3. Risks and events tracked and reported (Monitor, Inform, Mobilize, Evaluate, Research)
4. Enforcement actions taken for compliance (Enforce, Workforce)

#### **Prevention/health promotion**

1. Policies support prevention priorities (Monitor, Investigate, Inform, Policies, Workforce, Research)
2. Community involvement in setting priorities (Inform, Mobilize, Policies)
3. Access to prevention services (Inform, Mobilize, Services, Workforce, Evaluate, Research)
4. Prevention, early intervention provided (Mobilize, Policies, Services, Workforce)
5. Health promotion activities provided (Inform, Mobilize, Policies, Workforce, Evaluate, Research)

#### **Access to critical services**

1. Information on service availability (Monitor, Inform, Services)
2. Information shared on trends, over time (Investigate, Inform, Evaluate, Research)
3. Plans developed to reduce specific gaps (Inform, Mobilize, Policies, Services, Evaluate)
4. Quality and capacity monitored and reported (Inform, Enforce, Workforce, Evaluate, Research)



## **Appendix E**

### **City of Seattle Public Health Goals<sup>26</sup>**

#### **Attachment 1 to RESOLUTION**

#### **The City of Seattle Healthy Communities Initiative**

#### **Policy Guide for the City's Public Health Efforts and Investments**

#### **February 7, 2006**

Public health and community health services have a great impact on the health and well being of Seattle's residents and neighborhoods. One of the ways the City improves its residents' health is by investing in what are called enhanced public health services. King County, through Public Health—Seattle & King County (Public Health), is responsible for providing regional core public health services to residents throughout the county. Public Health's regional core services can be considered a "platform" or base of public health services that must be in place, and upon which the City of Seattle may choose to fund enhanced services. The City's investments are voluntary and are to be used for enhanced public health services benefiting Seattle residents.<sup>1</sup>

#### **The City of Seattle's vision for the health of the community**

This vision applies to all of the City's efforts to improve health conditions for Seattle's residents, as well as the City's specific investments in enhanced public health services.

*The people of Seattle will be the healthiest of any major city in the nation.*

There are many socioeconomic factors affecting the health of the community. This policy document focuses on the role of public and community health services in achieving this vision as well as on the City's more comprehensive work and investments that contribute to the public's health. The term health includes mental as well as physical health.

How successful we are in reaching this vision will be assessed in four ways. First, the City will compare Seattle's health indicators with the goals set by Healthy People 2010<sup>2</sup>, which is a set of national health objectives developed by the Centers for Disease Control and Prevention, the U.S. Surgeon General, and the U.S. Department of Health and Human Services, and endorsed by most states, including Washington. The overarching goals of Healthy People 2010 are to increase the quality and years of healthy life, and eliminate health disparities. Second, the City, in partnership with Public Health, will monitor health disparities. Our success in reaching the vision will be judged by how well

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<sup>1</sup> The City has no obligation to fund any enhanced public health service, with the exception, as delineated in RCW 70.96A.087, that a minimum of 2% of the City's share of state liquor taxes and profits must support alcohol and drug programs approved by the King County Alcoholism & Substance Abuse Board.

<sup>2</sup> When it is adopted, the City will use the nationally-recognized health objectives that will be promulgated to reach 2020 health goals, the successor to Healthy People 2010.

we are meeting/exceeding Healthy People 2010 objectives and whether disparities in health outcomes are being eliminated.

Thirdly, the Human Services Department (HSD) contracts with agencies to deliver health services and programs. All HSD contracts include measurable outcomes to be achieved and HSD evaluates compliance with all contract requirements.

Finally, HSD will assure there are mechanisms by which clients of city-funded services can provide feedback and information on how well city-funded health services are addressing their needs. This information will inform HSD's program performance assessments.

## **Goals for the City's public health efforts and investments**

These goals are applicable to all of the City's efforts to improve health conditions for Seattle's residents, as well as the City's specific investments in enhanced public health services. The City of Seattle recognizes that a continuum of public and community health services is necessary. This continuum must address health needs identified by public health data across the lifespan. Recognition will be given to the differing health needs of Seattle residents, including very young children, adolescents, pregnant women and older adults. The City's efforts and investments are focused on promoting the health of the public and, particularly, of groups who experience disparities in health outcomes.

1. **Eliminate health disparities** based on race, income, ethnicity, immigrant/refugee status, gender, sexual orientation, gender identity, health insurance status, neighborhood, or level of education.

Public health data analysis reveals that there are significant disparities in health outcomes based on race, ethnicity, income, immigrant/refugee status, health insurance status and neighborhood. These disparities are consistent across most health indicators. There are also major disparities based on gender affecting both women and men. Although little local population-based data on sexual minorities exist, national research indicates that there are significant disparities in health outcomes and risk factors based on sexual orientation. In addition, disparities tend to be interrelated; for example, there is a correlation between race and income level. People who are part of more than one disadvantaged group that experiences health disparities may experience greater health problems.

The City intends to increase the understanding of the causes of these health disparities and obtain additional local population-based data. The City will work with Public Health, Washington State and community and mainstream health providers to improve data collection.

Although the trends of most health indicators are improving overall, disparities persist. A primary focus of the City's efforts and funding is to increase understanding of and eliminate these disparities.

**2. Promote access to clinical and preventive health services.**

The City encourages and supports evidence-based strategies to:

- promote the early detection of disease;
- increase access to primary care, dental care and specialty care for the uninsured, underinsured, and Medicaid eligible;
- improve access to preventive health services, such as education and clinical services that promote healthy sexual behaviors; and
- provide access to culturally-appropriate clinical and preventive health services in order to address health needs identified by public health data and to reach groups experiencing disparities in health outcomes including immigrants and refugees.<sup>3</sup>

**3. Protect and foster the health and well being of communities through:**

- health promotion and disease and injury prevention activities;
- preparedness for emerging public health threats; and
- promotion of safe environments and protection from environmental hazards.

The City promotes strong communities by fostering healthy and safe physical environments that encourage active living and social cohesion and by engaging in community-based strategies that promote public health, including evidence-based strategies for improved nutrition, increased physical activity and decreased risky behaviors. The City prepares for public health emergencies, such as pandemic influenza and bioterrorism, through integration and coordination among the regional public health delivery systems and City emergency services and infrastructure.

**4. Support other City goals** such as ending homelessness, closing the academic achievement gap, ending domestic violence, and healthy aging.

Augment health services for the homeless to improve and stabilize their health as they improve other aspects of their lives such as housing and employment. Promote access to health services that have the potential to help children succeed in school. Support strategies that prevent domestic violence. Promote good nutrition and physical activity for all.

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<sup>3</sup> The City will work with its contractors, community and mainstream health providers, Public Health and others to adopt and implement guidelines and standards for culturally-appropriate clinical and preventive health services such as the Culturally and Linguistically Appropriate Services (CLAS) standards.

## The City's overall strategies to advance the vision and goals

For all of the following strategies the City uses data to inform all of its public health efforts and investments.

1. **Investments** – Invest in enhanced public health services for the purpose of improving health outcomes for Seattle residents and communities, outcomes that could not be expected from providing core public health services alone. The City encourages, promotes and invests in promising, innovative, community-based and collaborative strategies that address disparities in health outcomes.

City investments in public health services fund:

- a. enhanced services for Seattle residents that Public Health does not provide as part of its regional core responsibilities; (e.g., Enhanced tuberculosis services for the Seattle homeless population are not regional core services provided by Public Health); or
  - b. greater service levels to increase the number of people in Seattle who are served. (e.g., Seattle investments ensure that more Seattle at-risk second and third graders receive dental sealants through the community-based oral health program.)
2. **Partnerships** – Work in partnership with Public Health, the University of Washington and other public, community-based and private health-related organizations to improve the health of the community and to prevent and address public health problems. Maximize resources through public/private partnerships.

The City works in partnership with Public Health because a strong regional health department is critical to the health and well being of Seattle's people and communities. Public Health provides a rich array of regional core services and programs. It is the City's intention to help shape Public Health's services and activities in Seattle. The value of these services to Seattle is nearly \$100 million. Through the inter-local agreement between King County and the City of Seattle and through its membership on the King County Board of Health, the City works with Public Health to identify and address the public health needs of Seattle's residents and neighborhoods. The City has a strong working relationship with the University of Washington and facilitates connections between Public Health and the University in order to strategically advance the region's health and vitality. The City supports the continued connection between University research and public health practice, which historically has led to innovation and development of state-of-the art best practices.

In addition, the City works with other public, community-based, and private health-related organizations, including the King County Department of Community and Human Services, hospitals, community health centers, and

organizations focused on promoting the health of groups experiencing health disparities. The City's aim is to proactively address the health needs of Seattle's residents.

3. **City services and policies affecting the public's health** – Identify and adopt policies and provide services that contribute to improving the health, safety and well being of residents, families and neighborhoods. These include human services, prevention of domestic violence and sexual assault, aging and disabilities services, access to public benefits, food assistance, child care, housing, emergency preparedness, sidewalks, walking and bike trails, parks, jobs, transportation, land use policy, indoor air quality regulations and enforcement, and emergency medical services. Just as the City's investments and efforts in public health help to advance other City goals, these other City services contribute to the health of the community.
4. **Innovation.** Look for opportunities and promising community-based and collaborative strategies to achieve the City's vision and goals. The City welcomes new ideas, new voices, and new strategies in its approaches to addressing disparities in health outcomes and in all of the City's public health efforts and investments.

### **Policy framework and criteria to guide the City's investments in enhanced public health services**

The following criteria specifically applies to the City's investments in enhanced public health services. Prior to funding an enhanced service, the City will review the level of regional core public health services being provided to Seattle residents and the proportional distribution of resources to geographic areas and populations with the greatest unmet needs.<sup>4</sup>

Once that review is completed, the following policy framework and criteria will be used by the City to determine whether a service is an enhanced public health service that might be *considered* for City funding. Enhanced public health services funded by the City must meet all of the criteria listed in 1 through 5 below, including all of the sub-points under 4 and 5.

1. The enhanced service advances one or more of the City's four public health goals.

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<sup>4</sup> The City will review the level of regional core services being provided by Public Health for each program area in which the City is considering funding enhanced services. In the absence of standards for service levels that are to be developed under the King County Operational Master Plan for Public Health, HSD, in consultation with public health experts, will make its best assessment of whether the County is fulfilling its responsibility to adequately provide regional core services. If necessary, HSD will work with Public Health to increase the provision of core services to target populations.

2. The enhanced service addresses an identified health need that is documented with public health data and is not being addressed adequately through existing public health or community efforts.
3. The enhanced service includes a coherent strategy to address disparities in health outcomes and to effectively reach the target population.
4. The enhanced service will likely result in measurable outcomes for either the community as a whole or for specific groups experiencing health disparities.<sup>5</sup>
  - a) The enhanced service improves health outcomes that would not likely result from the provision of regional core public health services alone.
  - b) The expected outcomes are justified by the investment.
5. The enhanced service must be based on sound public health, service delivery and administrative practices.
  - a) The service reflects evidence-based practices or promising innovative, community-based or collaborative strategies.
  - b) The service delivery system is culturally competent and is likely to serve the target population effectively.
  - c) City funding is critical to addressing the need—no other resources are available, or City funding leverages other funds.
  - d) The investment is cost-effective. Provider costs are reasonable and justifiable.
  - e) The investment is significant enough to be administratively efficient and to yield measurable results.
  - f) There is a contracted commitment on the part of the provider to document use of City funds and to track, achieve and report outcomes and milestones.

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<sup>5</sup> Since many health problems, including narrowing disparities, are complex and require significant resources and time to address, measuring some outcomes will be a long-term endeavor.

## **Appendix F**

### **Policy Environment Impacts of Standards on PHSKC**

#### **Organized by the 10 Essential services**

#### **1. Assessment Standards: Monitor health status and understand health issues facing the community**

#### **Relevant Washington State Standards: AS1, AS2, AS5, EH3**

#### **PHSKC Policy Environment Impacts**

- Mandated by RCW and WAC to collect reportable diseases information, and analyze and report on these data.
- Mandated by federal HIPAA law to maintain confidentiality of health data.
- Required to track status of major health indicators and identify emerging trends for Board of Health, local government and PHSKC. Need to respond to data requests from these customers in timely fashion. This entails presentations, preparation of special reports, etc.
- Obligated to fulfill deliverables on assessment activities funded by external funders such as private foundations. An increasing proportion of assessment activities are funded in this way due to limited local and state governmental funds that are not keeping pace with inflation. Assessment activities in response to these demands include primary data collection (obtaining raw data through surveys and qualitative methods), acquisition of secondary data (large data sets from state, census, health care organizations, etc.), development of analytic methods and software, analysis of data, reporting of findings, collaboration with stakeholders in report development. The department has a minimum set of deliverables each year for its assessment activities, including one major report, two Data Watches (shorter, more narrowly focused topical reports), and timely response to data requests.
- Obligated to carry out assessment linked to policy and program development in order to be consistent with the department's value of evidence-based planning and policy development. This requires assessment staff participation in planning and policy development activities department- (and community-) wide (e.g. custom data analysis to support development of a particular policy, review of evidence for best practices in addressing a specific health issue).
- Obligated to use a collaborative process to determine priorities and scope of assessment activities. The process includes both internal

and external stakeholder in identifying priorities for assessment, generating questions to be addressed by assessment, discussing best ways of obtaining data, reviewing analysis and participation in interpretation and dissemination of findings.

- Interested in finding some sustainable assessment activities that support a community health model.
- Lack of funding and reliance on temporary grant sources.

## **2. Protection: Protect people from health problems and health hazards.**

**Relevant State Standards: AS5, CD1, CD2, CD3, CD4, CD5, EH1, EH2, EH3, EH4, PP1, PP3, PP4, PP5**

### **Policy Environment Impacts**

- The health department enjoys a high level of support from elected and appointed policy makers including the Board of Health
- Washington law now prohibits smoking in all public places and places of employment, so the focus of the health department's efforts can shift from policy to enforcement and prevention.
- HIPAA requirements and restrictions limit the ability of clinical programs in the department to communicate with patients/clients in ways that could enhance services and access of services to those who need them.
- The State Department of Health approaches public health preparedness by establishing core capabilities across the state rather than allocating resources to appropriately address risk, vulnerability and complexity of response regions. For example, state funding policies spread resources evenly by county, so King County gets 40% of the funding yet has 60% of the statewide TB cases.
- A dominant focus at the federal and state level on hospital preparedness has created vulnerability in other areas for metropolitan areas. With half the statewide total of hospital beds located in this one metro county, resources are still spread evenly statewide. This distribution of funds significantly hampers the ability of PHSKC and other CMHD to coordinate preparedness efforts across the entire health care system. Federal agencies prioritizing equipment purchases for hospitals, rather than enabling them to identify their critical needs based on a set of measurable objectives



has created inefficiency and duplication of effort across funding sources.

- Direct CDC funding for public health preparedness to MMHDs up to this point has only been made available to New York City, Chicago, Washington DC and Los Angeles. This fails to acknowledge the special needs of other large cities' health departments, which are arguably as great in some respects as those facing these three cities.
- CDC funding for Public Health Preparedness has thus far excluded a focus on chemical and radiological threats.
- "Healthy Planning" is a primary prevention environmental health approach that takes into account health consequences related to water, air, noise, injuries, physical activity, food security, access and social cohesion. With resources, this effective approach could be more widely adopted by the department.
- Efforts such as healthy planning are good for the economic healthy of the region.
- Social cohesion is an important emergency preparedness strategy, especially for vulnerable populations.
- County policies and procedures governing travel can make it difficult for the Department to ensure its employees have ready access to training and conferences that are needed to maintain skills at the level required to ensure optimal protection of the health of the public.

<b>3. Health Information: Give people information they need to make healthy choices.</b>
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**Relevant Washington State Standards: CD4, PP3, EH2, AC1**

**Policy Environment Impacts**

- Federal regulations that require the delivery of health messaging that contradict scientifically accurate messaging have increased the need for resources from other revenue streams to deliver both mandated messages and technically accurate information.
- PHSKC has a number of health educators working with a population based focus with school districts, community-based organizations (CBOs) and community gatekeepers to deliver effective health information. Much of the work is focused on training the trainers, i.e.

teachers, CBO and community workers, to deliver this messaging to their constituents. The ability to do this consistently and effectively is limited by resources.

- PHSKC plans to encourage the adoption of policy that recommends or requires health care institutions be trained to CLAS standards to assure cultural competent health care delivery.
- The mandated use of county-defined graphic design and production facilities restricts the departments' ability to rapidly produce high quality materials in large volumes.

#### **4. Community Engagement: Engage the community to identify and solve health problems.**

**Relevant Washington State Standards: AS4, PP1, PP2, PP3, EH1, AC3**

##### **Policy Environment Impacts**

- The local policy environment is highly complex and includes a number of policy making bodies: the King County Board of Health, the King County Council, 39 city councils, and 19 school boards, a policy framework for the City of Seattle to guide public health efforts and investments.
- Washington State Public Health Standards require the following local measures that relate to community engagement:
  - 1) There is a planned systematic process that describes how health assessment data is used to guide health policy decisions.
  - 2) The PHSKC coordinates and works with a broad range of community partners in considering assessment information to set prevention priorities.
- PHSKC engages the local public health system to establish goals and solve problems through a multi-layered approach that includes public sector, health delivery system and community partnerships across the many levels. Community health assessment information and both categorical and broader partnerships are used to increase awareness of health concerns, inform priorities and develop policy and programmatic interventions.
- Community engagement activities across all regions of King County include:
  - Community-based partnerships and coalitions to address focused health promotion/ disease prevention activities, health access and to eliminate health disparities.

- Dissemination and dialogue on community assessment information with policy makers, planners and community based organizations across the County.
- Technical assistance with multiple jurisdictions to develop response plans for communicable disease outbreaks and other public health emergencies.
- By sponsoring and participating in the King County Health Action Plan, the Puget Sound Health Alliance and the Health Care Coalition, the department influences the policy decisions of private institutions throughout the county and elsewhere in ways that focus attention on prevention and preparedness.
- The department's connections to the business community have helped the region become prepared for a possible pandemic flu. The County also has implemented innovative worksite wellness practices, with assistance from the department.

## **5. Policy Development: Develop public health policies and plans.**

### **Relevant Washington State Standards: PP1, PP4**

#### **Policy Environment Impacts**

- The local policy environment is highly complex and includes a number of policy making bodies: the King County Board of Health, the King County Council, City of Seattle, 39 Suburban City Councils, and 19 school boards. Other county departments that create and influence public health policy include the Department of Natural Resources and Parks, the Department of Transportation, the Department of Adult and Juvenile Detention, the Department of Community and Human Services. In addition, regional entities, such as the Puget Sound Regional Council operate in the local jurisdiction.
- Federal, State, and local legislators set policy, mandate provision of Public Health services and, in some instances, dictate how services will be provided. These entities include the federal Department of Health and Human Services, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and state agencies, such as the Department of Health, the Department of Social and Health Services, and the Department of Ecology.
- For example, Federal regulations dictate that patients cannot be turned away because of inability to pay. Interpretation services must be available to all non English speaking patients/clients seeking Public Health services.

- At the State level, Public Health Standards have been adopted as policy and apply to the local governmental public health system in the following areas: understanding health issues, protecting people from disease, ensuring a safe and healthy environment, promoting healthy living and helping people get the services they need. The City of Seattle is establishing the “Healthy Communities Initiative” a policy framework to guide enhanced public funding and influence public health services in the City of Seattle.
- Washington State is a ‘Home Rule’ State, which means that local jurisdictions, including municipalities, have powers to set policies.
- Within the State, King County is viewed as atypical of counties in the “state” which can cause policy and funding friction with other jurisdictions.

## **6. Enforcement: Enforce public health laws and regulations.**

### **Relevant Washington State Standards: EH 4**

#### **Policy Environment Impacts**

- New information leads to updated and/or new codes which may or may not be welcomed by stakeholders.
- Stakeholders are generally opposed to fees and fee increases associated with these regulations.
- Stakeholders generally feel that these programs and services should be supported by general tax dollars at the same time that there is substantial public pressure to hold the line on such taxes.
- There a growing demand for stakeholder involvement in the design and execution of our regulatory programs which seems contradictory to the traditional enforcement approach.
- The ability to gather and analyze data relating to enforcement activities may serve as a factor in future policy decisions by the Board of Health.

## **7. Access: Help people receive health services.**

### **Relevant Washington State Standards: PP3, PP4, PP5, AC1, AC2, AC3, AC4**

#### **Policy Environment Impacts**

- The federal government is unwilling to lead the type of reform required to assure universal access to health care.

- The federal government can and does impose unfunded mandates for health services (requirements for access to interpretation services, HIPAA) that add to the costs of providing services and which has an unintended consequence of decreasing access to services and/or interest of some providers in serving vulnerable populations.
- The federal budget is targeting reductions to existing funding for Medicaid and Take Charge (family planning) funding, which will result in reductions in service levels for low income clients – with the risk of increasing health disparities.
- State agencies are limited in their ability to push back on changes required by the federal government in areas with partial federal funding.
- State government is supporting incremental efforts to ensure health insurance coverage for all children by 2010, but waiting lists for BHP and immigrant children cause disparities in access to widen.
- PHSKC leads in coordinating with community partners and government to promote increased access to health insurance coverage or funding for services directed at un- or under-insured populations.
- KC is a leader in the effort to improve health care quality while reducing costs in the activities of the Puget Sound Health Alliance.
- KC and PHSKC have created an appropriate infrastructure, through the new Health Care Coalition on emergency preparedness, to work with community providers and health systems to better coordinate the health care system to respond to the care needs of vulnerable populations while distributing the risks of providing this care more equitably. There is optimism that this preparedness practice will lead to greater coordination and burden sharing in the everyday health responsibilities of all partners
- A thorough assessment of the health of King County is performed every decade and serves as a roadmap for strategic health policy and program foci for the department.

## **8. Workforce Development Standards: Maintain a competent public health workforce.**

**Relevant Washington State Standards: All standards reference the need to have well trained and qualified staff.**

### **Policy Environment Impacts**

- PHSKC's workforce is >80% unionized. PHSKC has 12 Collective Bargaining agreements many of which have different provisions for basic personnel practices such as leave provisions, OT/Comp Time, seniority calculations and promotional rights.
- King County policy which provides an additional 12 weeks of Family Medical Leave (FMLA) to the federally required FML creates extended authorized absences which must be filled by temporary hires, rather than permanent hires
- The unfunded HIPAA policy requires a significant investment in a security and privacy infrastructure using funds that could otherwise be invested in other functions
- Need to engage public health academic programs to prepare public health workforce for changing practice environment.

## **9. Evaluation: Evaluate and improve programs and interventions**

**Relevant Washington State Standards: AS2, PP3, PP5, CD5**

### **Policy Environment Impacts**

- County contracting practices can compromise the flexibility and speed with which the department is able to respond, and limit options for evaluation activities.
- KC travel restrictions make it difficult for staff to attend professional meetings and to learn about current evidence and state of the art practice.
- Funders often require evaluations/research yet PHSKC has limited capacity to conduct research/evaluation in terms of sufficient availability of qualified staff
- Limited mechanisms exist to effectively connect academic researchers with research issues of importance to local public health.

- HIPAA policy interpretation within the department does not allow public health to collect evaluation information from or contact clients via the internet or email.

<b>10. Evidence: Contribute to and apply the evidence base of public health.</b>
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**Relevant Washington State Standards: N/A**

**Policy Environment Impacts**

- Funders often require research activities yet PHSKC lacks widespread capacity to conduct research in terms of sufficient availability of qualified staff. This in turn limits PHSKC ability to compete for grants which contain both program and research components.
- Limited mechanisms to effectively connect academic researchers with research issues of importance to local public health.
- Many times grant opportunities do not allow for promising programs to be implemented and evaluated and thus expansion of the evidence-based body of work in public health progresses slower than other health areas.